Core Assessment

Demographics

Now I'm going to ask you some background questions about yourself.

3) What is your current marital status?

- ☐ Married/Partnered
- ☐ Separated
- ☐ Divorced
- ☐ Never Married
- ☐ Widowed

4) How many people live with you?

- ☐ Alone
- ☐ One other
- ☐ More than one
- ☐ Refused

5) Which of the following best describes you?

- ☐ White
- ☐ Black/African American
- ☐ Asian/Pacific Islander
- ☐ Native American/Alaskan
- ☐ Refused
- ☐ Other/Mixed

5b) Are you Hispanic?

- ☐ YES
- ☐ NO

6) Do you currently smoke?

- ☐ YES
- ☐ NO

6a) Have you ever considered quitting?

- ☐ YES
- ☐ NO

7) On the whole, how much do your friends and relatives make you feel loved and cared for?

- ☐ A great deal
- ☐ Quite a bit
- ☐ Some

- A little
- Not at all
- Refused

8) Do you receive the majority of your primary health care at the VA?

- YES
- NO

8a) Did you serve in the Iraq or Afghanistan conflicts?

- YES
- NO

9) In the past two years, have you had an appointment with a counselor, psychiatrist, therapist or social worker?

- YES
- NO
- Don't Know/Refused

9c) Is this provider affiliated with your primary care provider (in the same clinic or hospital)?

- YES
- NO

9a) What is the name of the mental health care provider?

9b) When was the last time you saw him/her (in weeks)?

9d) Are you aware of an upcoming appointment with your mental health or substance abuse provider?

- YES
- NO

10) Are you doing any kind of work that you are paid for?

- YES
- NO

10a) Do you work full or part-time?

- Full time
- Part time
- Refused

11) Thinking about your financial situation, would you say that you:

- Can’t make ends meet
- Have just enough to get along
- Are comfortable

- ☐ Refused

12) Have you ever experienced a significant head injury?

- ☐ YES
- ☐ NO

12a) Did you lose consciousness with any of these injuries?

- ☐ YES
- ☐ NO

12b) How long were you unconscious (longest time)?

- ☐ Less than 20 minutes
- ☐ 20 minutes - 1 hour
- ☐ > 1 hour
- ☐ Don't know

Blessed Memory Test

Now I would like to ask you some questions to check your memory and concentration. Some of the questions may be easy and some of them may be hard.

1) What year is it now?

- ☐ 0
- ☐ 1

2) What month is it now?

- ☐ 0
- ☐ 1

Please repeat this phrase after me: "John Brown, 42 Market Street Chicago." I will be asking you to repeat this phrase to me in a few minutes."

3) About what time is it? (Correct within 1 hour)

- ☐ 0
- ☐ 1

4) Now I would like you to count backwards from 20 to 1.

- ☐ 0
- ☐ 1
- ☐ 2

5) Now I would like you to say the months of the year in reverse order.

- ☐ 0

- ☐ 1
- ☐ 2

6) Now please repeat the memory phrase.

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5

7) How would you describe your memory?

- ☐ Normal memory? Or do you…
- ☐ Occasionally forget things but not to the point where this causes many problems?
- ☐ Mild consistent forgetfulness
- ☐ Have moderate memory loss, that causes problems with everyday activities
- ☐ Substantial memory loss
- ☐ Refused

8) Do you have any problems with hearing?

- ☐ YES
- ☐ NO

8a) Does this interfere with your ability to communicate?

- ☐ YES
- ☐ NO

9) Do you have any problems with speaking?

- ☐ YES
- ☐ NO

9a) Does this interfere with your ability to communicate?

- ☐ YES
- ☐ NO

10) Have you been drinking alcohol or using any illicit drugs in the last 24 hours?

- ☐ Yes – alcohol
- ☐ Yes – drugs
- ☐ Yes -both
- ☐ No
- ☐ Refused

Mania

Now I am going to get into questions about how you are feeling. Please bear with me as I know these questions can be repetitive at times but all the questions are important.

D1) Have you ever had a period when you were feeling 'up' or 'high' or so full of yourself that you got into trouble or that other people thought you were not your usual self? Do not consider the times you were on drugs or alcohol. If the patient is unclear about 'up' or 'high' clarify as follows: By 'up' or 'high' I mean: Having a period of time outside your normal everyday personality where you might have had elevated moods; being on top of the world; energy; needing less sleep; having rapid thoughts; being full of ideas; having an increase in productivity, motivation, creativity or impulsive behavior.

- ☐ YES
- ☐ NO

D1a) If Yes: Are you currently (last month) feeling 'up' or 'high' or full of energy?

- ☐ YES
- ☐ NO

D2) Have you ever been persistently irritable for several days, so that you had arguments or verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or overreacted, compared to other people, even in situations where you felt justified? Do not consider the times you were intoxicated on drugs or alcohol.

- ☐ YES
- ☐ NO

D2a) If Yes: Are you currently (last month) feeling persistently irritable?

- ☐ YES
- ☐ NO

When you feel high, or full of energy, or irritable, do you...

D3a) Feel that you could do things that others couldn't do or that you were an especially important person?

- ☐ YES
- ☐ NO

D3b) Need less sleep?

- ☐ YES
- ☐ NO

D3c) Talk too much without stopping or so fast that people had a hard time understanding?

- ☐ YES
- ☐ NO

D3d) Have racing thoughts?

- ☐ YES

- ☐ NO

D3e) Easily distracted?

- ☐ YES
- ☐ NO

D3f) Become so active or physically restless that others worried about you?

- ☐ YES
- ☐ NO

D3g) Want so much to engage in pleasurable activities that you ignored risks or consequences?

- ☐ YES
- ☐ NO

D4) Did these symptoms last at least a week and cause you significant problems at home, work, at school, or were you ever hospitalized for these problems?

- ☐ YES
- ☐ NO

PATIENT HEALTH QUESTIONNAIRE (PHQ)

Now I am going to ask you some questions about how you have been feeling over the last two weeks.

1) How often in the last two weeks have you had little interest or pleasure in doing things?

- ☐ Not at all
- ☐ Several Days
- ☐ More than half the days
- ☐ Nearly every day

2) How often in the last two weeks did you feel down, depressed or hopeless?

- ☐ Not at all
- ☐ Several Days
- ☐ More than half the days
- ☐ Nearly every day

3) How often in the last two weeks did you have trouble falling or staying asleep or find yourself sleeping too much?

- ☐ Not at all
- ☐ Several Days
- ☐ More than half the days
- ☐ Nearly every day

4) How often in the last two weeks have you felt tired or had little energy?

- ☐ Not at all
- ☐ Several Days
- ☐ More than half the days
- ☐ Nearly every day

5) How often in the last two weeks did you have a poor appetite or found yourself over-eating?

- ☐ Not at all
- ☐ Several Days
- ☐ More than half the days
- ☐ Nearly every day

6) How often in the last two weeks did you feel bad about yourself, felt that you were a failure, or felt that you let yourself or your family down?

- ☐ Not at all
- ☐ Several Days
- ☐ More than half the days
- ☐ Nearly every day

7) How often in the last two weeks did you have trouble concentrating on things, such as reading the newspaper or watching television?

- ☐ Not at all
- ☐ Several Days
- ☐ More than half the days
- ☐ Nearly every day

8) In the last two weeks have you found yourself moving or speaking slowly, or have you been fidgety or restless such that other people have noticed?

- ☐ Not at all
- ☐ Several Days
- ☐ More than half the days
- ☐ Nearly every day

9) In the last two weeks, did you have any thoughts that you would be better off dead, or did you think about hurting yourself in some way?

- ☐ Not at all
- ☐ Several Days
- ☐ More than half the days
- ☐ Nearly every day

10) How difficult have these problems made it for you to do your work, take care of things at home, or get along with others?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very Difficult
- ☐ Extremely Difficult

11) How long have you been feeling this way?

Psychosis

"Now I am going to ask you about some unusual experiences that people sometimes have."

K1) Have you ever heard things that other people could not hear, such as voices?

- ☐ YES
- ☐ NO

K1a) If Yes: Have you heard these things in the past month?

- ☐ YES
- ☐ NO

K2) Have you ever had visions when you were awake or have you ever seen things that other people could not see?

- ☐ YES
- ☐ NO

K2a) If Yes: Have you seen these things in the past month?

- ☐ YES
- ☐ NO

K3) Have your relatives or friends ever considered any of your beliefs strange or unusual?

- ☐ YES
- ☐ NO

K3a) If Yes: Do they currently consider your beliefs strange and unusual?

- ☐ YES
- ☐ NO

K4) You told me earlier that you had period(s) when you felt depressed or down or uninterested in most things. Were the beliefs and experiences you just described restricted exclusively to times when you were feeling depressed or down?

- ☐ YES
- ☐ NO

Past and Current Depression Treatment

1) During the past month, did you take any medications, prescribed or not, for depression, anxiety or nerves?

- ☐ YES
- ☐ NO

1a) Antidepressants (Mark all that apply).

- ☐ Amitriptyline
- ☐ Amoxapine
- ☐ Bupropion
- ☐ Celexa
- ☐ Citalopram
- ☐ Cymbalta
- ☐ Desipramine
- ☐ Desyrel
- ☐ Doxepin
- ☐ Duloxetine
- ☐ Escitalopram
- ☐ Effexor
- ☐ Fluoxetine
- ☐ Fluvoxamine
- ☐ Imipramine
- ☐ Lexapro
- ☐ Luvox
- ☐ Maprotiline
- ☐ Mirtazapine
- ☐ Nardil
- ☐ Nefazodone
- ☐ Nortriptyline
- ☐ Pamelor
- ☐ Paroxetine
- ☐ Paxil
- ☐ Phenelzine
- ☐ Prozac
- ☐ Remeron
- ☐ Sertraline
- ☐ Serzone
- ☐ Surmontil
- ☐ Tranylcpromine
- ☐ Trazadone
- ☐ Trimitramine
- ☐ Venlafaxine
- ☐ Wellbutrin
- ☐ Zoloft

1b) When did you start taking this medication?

1c) Antianxiety Medications (Mark all that apply)

- ☐ alprazolam
- ☐ ativan
- ☐ buspar
- ☐ busparone
- ☐ chloral hydrate
- ☐ chlordiazepoxide
- ☐ clonazepam
- ☐ dalmane
- ☐ diazepam
- ☐ estalzolam
- ☐ hydroxyzine
- ☐ Klonopin
- ☐ Librium
- ☐ lorazepam
- ☐ oxazepam
- ☐ prosom
- ☐ Restoril
- ☐ serax
- ☐ temazepam
- ☐ Tranxene
- ☐ Valium
- ☐ xanax
- ☐ zaleplon

1d) Other Psychiatric Medications (Mark all that apply)

- ☐ abilify
- ☐ Acamprosate
- ☐ antabuse
- ☐ aripiprazole
- ☐ buprehorphine
- ☐ campral
- ☐ Carbamazepine
- ☐ chlorpromazine
- ☐ clozapine
- ☐ Clozaril
- ☐ Cylert
- ☐ depakote
- ☐ disulfirim
- ☐ Divalpoex

- ☐ haloperidol
- ☐ eskalith/lithobid
- ☐ Geodon
- ☐ haldol
- ☐ Lamotrigine
- ☐ loxapine
- ☐ Loxitane
- ☐ mellaril
- ☐ mesoridazine
- ☐ methadone
- ☐ Methylphenidate
- ☐ thioridazine
- ☐ naltrexone
- ☐ navane
- ☐ olanzapine
- ☐ Pemoline
- ☐ perphanzine
- ☐ pimozide
- ☐ prolixin
- ☐ quetiapine
- ☐ revia
- ☐ riperidone
- ☐ Risperdal
- ☐ Seroquel
- ☐ Suboxone/Subutex
- ☐ tegretol
- ☐ thiothixene
- ☐ thorazine
- ☐ trilafon
- ☐ Valproic acid
- ☐ Ritalin
- ☐ Ziprasidone
- ☐ zyprexa

1e) If not listed above note here:

2) Have you considered treatment for your depressive symptoms?

- ☐ No-other reasons
- ☐ No-tried in the past didn't work
- ☐ No-I do not consider myself depressed
- ☐ Would consider treatment
- ☐ Refused

3) In the past, have you ever had two weeks or more when nearly every day you

felt blue or depressed? (If 'No'): have you ever had two weeks or more when nearly every day you lost all interest in things like work or hobbies or things you usually liked to do for fun?

- ☐ YES
- ☐ NO

3a) During this time have your work, activities or relationships suffered?

- ☐ YES
- ☐ NO

3b) Did you take medication for depression or receive treatment from your doctor or a mental health specialist?

- ☐ YES
- ☐ NO

Alternative Medications

1) In the last three months, have you taken any nonprescription medications or herbal remedies to help you with your mood or energy? This includes: St. John's Wort, Ginkgo, Ginseng, Kava Kava, Lyndon Tea, Chamomile, DHEA, Valerian, Sam-E, Melatonin.

- ☐ YES
- ☐ NO

2) Now I am going to ask about each of these medications or herbal remedies. I will need the name of each different medication that you took for a month or more in the past three months.

Still using: ☐ YES ☐ NO
Still using: ☐ YES ☐ NO
Still using: ☐ YES ☐ NO

Suicidal Ideation

1) Has there been a time in the last year when you thought life was not worth living?

- ☐ YES
- ☐ NO

2) Has there been a time in the last year that you wished you were dead, for instance you would go to sleep and not wake up?

- ☐ YES
- ☐ NO

3) Has there been a time in the last year that you thought of taking your own life, even if you would not really do it?

- ☐ YES
- ☐ NO

4) Has there been a time in the last year when you reached a point where you seriously considered taking your own life or perhaps made plans about how you would go about doing it?

- ☐ YES
- ☐ NO

5) In the last year, have you made an attempt on your life?

- ☐ YES
- ☐ NO

Alcohol use

1) Have you drank any beer, wine, or liquor in the past 3 months?

- ☐ YES
- ☐ NO
- ☐ Don't Know
- ☐ Refused

2) Has there been a time in the past that you or someone else considered your drinking a problem or that you felt you drank excessively?

- ☐ YES
- ☐ NO
- ☐ Don't Know
- ☐ Refused

How many standard drinks* have you consumed each day for the past seven days. Day seven corresponds to the yesterday. Please provide the answers below:

2a1) Day 1 (Yesterday)

2a2) Day 2

2a3) Day 3

2a4) Day 4

2a5) Day 5

2a6) Day 6

2a7) Day 7

3) During the past 3 months, how many times have you had 5 or more drinks in a single day? (4 or more if over age 64 or female?

Alcohol use and dependence

In the past 12 months:

1) Did you need to drink more in order to get the same effect that you got when you first started drinking?

- ☐ YES
- ☐ NO

2) When you cut down on drinking, did your hands shake, did you sweat or feel agitated? Did you drink to avoid these symptoms or to avoid being hung-over, for example, "the shakes", sweating or agitation?

- ☐ YES
- ☐ NO

3) During the times when you drank alcohol, did you end up drinking more than you planned when you started?

- ☐ YES
- ☐ NO

4) Have you tried to reduce or stop drinking alcohol but failed?

- ☐ YES
- ☐ NO

5) On the days that you drank, did you spend substantial time in obtaining alcohol, drinking, or in recovering from the effects of alcohol?

- ☐ YES
- ☐ NO

6) Did you spend less time working, enjoying hobbies or being with others because of your drinking?

- ☐ YES
- ☐ NO

7) Have you continued to drink even though you knew the drinking caused you health or mental problems?

- YES
- NO

8) Have you been intoxicated, high, or hung-over more than once when you had other responsibilities at school, at work, or at home? Did this cause any problems?

- YES
- NO

9) Were you intoxicated more than once in any situation where you were physically at risk, for example, driving a car, riding a motorbike, using machinery, boating, etc.?

- YES
- NO

10) Did you have legal problems more than once because of your drinking, for example, an arrest or disorderly conduct?

- YES
- NO

11) Did you continue to drink even though your drinking caused problems with your family or other people?

- YES
- NO

12) Have you considered cutting down on your drinking?

- Yes
- No- I don't drink too much
- No- I've tried before
- No- Other
- Refused

13) Has your primary care provider suggested that you cut down on your drinking?

- YES
- NO

Illicit drug and medication misuse

1) I would like to ask you some questions about your use of street drugs like cocaine, heroin, marijuana, speed, LSD, inhalants, barbiturates, or hallucinogens. Have you ever used any of these substances?

- YES
- NO

In the past year how many times have you done the following drugs ?

1a1) Cocaine (in the past 1 year)?

- ☐ Never
- ☐ Less than 10
- ☐ More than 10
- ☐ Refused

1b1) Cocaine (more than a year ago) ?

- ☐ Never
- ☐ Less than 10
- ☐ More than 10
- ☐ Refused

1a2) Heroin (in the past 1 year)?

- ☐ Never
- ☐ Less than 10
- ☐ More than 10
- ☐ Refused

1b2) Heroin (more than a year ago) ?

- ☐ Never
- ☐ Less than 10
- ☐ More than 10
- ☐ Refused

1a3) Marijuana (in the past 1 year)?

- ☐ Never
- ☐ Less than 10
- ☐ More than 10
- ☐ Refused

1b3) Marijuana (more than a year ago) ?

- ☐ Never
- ☐ Less than 10
- ☐ More than 10
- ☐ Refused

1a4) Speed (in the past 1 year)?

- ☐ Never
- ☐ Less than 10
- ☐ More than 10
- ☐ Refused

1b4) Speed (more than a year ago) ?

- ☐ Never
- ☐ Less than 10
- ☐ More than 10
- ☐ Refused

1a5) LSD (in the past 1 year)?

- ☐ Never
- ☐ Less than 10
- ☐ More than 10
- ☐ Refused

1b5) LSD (more than a year ago) ?

- ☐ Never
- ☐ Less than 10
- ☐ More than 10
- ☐ Refused

1a6) Inhalants (in the past 1 year)?

- ☐ Never
- ☐ Less than 10
- ☐ More than 10
- ☐ Refused

1b6) Inhalants (more than a year ago) ?

- ☐ Never
- ☐ Less than 10
- ☐ More than 10
- ☐ Refused

1a7) Barbiturates (in the past 1 year)?

- ☐ Never
- ☐ Less than 10
- ☐ More than 10
- ☐ Refused

1b7) Barbiturates (more than a year ago) ?

- ☐ Never
- ☐ Less than 10
- ☐ More than 10

- [ ] Refused

1a8) Club Drugs (in the past 1 year)?

- [ ] Never
- [ ] Less than 10
- [ ] More than 10
- [ ] Refused

1b8) Club Drugs (more than a year ago) ?

- [ ] Never
- [ ] Less than 10
- [ ] More than 10
- [ ] Refused

2) In the last 6 months have you intentionally misused prescription medications? (misused means taking more medication than you supposed to or taking prescription medication not prescribed to you).

- [ ] YES
- [ ] NO

2a) How many times in the last 6 months have you intentionally misused prescription drugs:

- [ ] Seldom (once or twice)
- [ ] Several times (3-6 times)
- [ ] Often (more than 6 times)

Panic Disorder

1) Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable, or uneasy, even in situations where most people would not feel that way?

- [ ] YES
- [ ] NO

1a) Did the spells peak within 10 minutes?

- [ ] YES
- [ ] NO

2) At any time in the past, did any of those spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner?

- [ ] YES
- [ ] NO

3) Have you ever had one such attack followed by a month or more of persistent fear of having another attack, or worry about the consequences of another attack?

- ☐ YES
- ☐ NO

During the last spell that you can remember....

4a) Did you have skipping, racing or pounding of your heart?

- ☐ YES
- ☐ NO

4b) Did you have sweaty or clammy hands?

- ☐ YES
- ☐ NO

4c) Were you trembling or shaking?

- ☐ YES
- ☐ NO

4d) Did you have shortness of breath or difficulty breathing?

- ☐ YES
- ☐ NO

4e) Did you have a choking sensation or a lump in your throat?

- ☐ YES
- ☐ NO

4f) Did you have chest pain, pressure or discomfort?

- ☐ YES
- ☐ NO

4g) Did you have nausea, stomach problems or sudden diarrhea?

- ☐ YES
- ☐ NO

4h) Did you feel dizzy, unsteady, lightheaded or faint?

- ☐ YES
- ☐ NO

4i) Did things around you feel strange, unreal, or did you feel outside of or detached from part or all of your body?

- ☐ YES
- ☐ NO

4j) Did you fear that you were losing control or going crazy?

- ☐ YES
- ☐ NO

4k) Did you fear that you were dying?

- ☐ YES
- ☐ NO

4l) Did you have tingling or numbness in parts of your body?

- ☐ YES
- ☐ NO

4m) Did you have hot flashes or chills?

- ☐ YES
- ☐ NO

5) In the past month, did you have such attacks repeatedly (2 or more), followed by a persistent fear of having another attack?

- ☐ YES
- ☐ NO

Generalized Anxiety Disorder

1) Have you worried excessively or been anxious about several things over the past 6 months?

- ☐ YES
- ☐ NO

1a) If Yes: Are these worries present on most days?

- ☐ YES
- ☐ NO

2) Do you find it difficult to control the worries or do they interfere with your ability to focus on what you are doing?

- ☐ YES
- ☐ NO

When you were anxious over the last 6 months, did you, most of the time...

3a) Feel restless, keyed up, or on edge?

- ☐ YES
- ☐ NO

3b) Feel tense?

- ☐ YES
- ☐ NO

3c) Feel tired, weak or exhausted easily?

- ☐ YES
- ☐ NO

3d) Have difficulty concentrating or find your mind going blank?

- ☐ YES
- ☐ NO

3e) Feel irritable?

- ☐ YES

- ☐ NO

3f) Have difficulty sleeping (falling asleep, waking up in the middle of the night or early in the morning or sleeping excessively)?

- ☐ YES
- ☐ NO

Post traumatic stress disorder

1) Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or to someone else?

- ☐ YES
- ☐ NO

2) During the past month, have you experienced that event in a distressing way, such as in dreams or intense recollections, flashbacks, or physical reactions?

- ☐ YES
- ☐ NO

During the past month...

3a) Have you avoided thinking about the event, or have you avoided things that remind you of the event?

- ☐ YES
- ☐ NO

3b) Have you had trouble recalling some important part of what happened?

- ☐ YES
- ☐ NO

3c) Have you become less interested in hobbies or social activities?

- ☐ YES
- ☐ NO

3d) Have you felt detached or estranged from others?

- ☐ YES
- ☐ NO

3e) Have you noticed that your feelings are numb?

- ☐ YES
- ☐ NO

3f) Have you felt that your life would be shortened by this trauma?

- ☐ YES
- ☐ NO

During the past month...

4a) Have you had difficulty sleeping?

- ☐ YES
- ☐ NO

4b) Were you especially irritable or did you have outbursts of anger?

- ☐ YES
- ☐ NO

4c) Have you had difficulty concentrating?

- ☐ YES
- ☐ NO

4d) Were you nervous or constantly on your guard?

- ☐ YES
- ☐ NO

4e) Were you easily startled?

- ☐ YES
- ☐ NO

5) During the past month, have these problems significantly interfered with your work or social activities, or caused significant problems?

- ☐ YES
- ☐ NO

6) How old were you when you first began having these symptoms? (Years)

7) During the past year, for how many months have you had these symptoms? (Months)

Bed days

1) On average, about how many days per week do you work for employment?

2) During the past 4 weeks, about how many days did illness or injury cause you to miss work for more than half a day?

3) During the past 4 weeks, about how many days did you stay in bed for more than half the day because of illness or injury?

SF-12 v.2

The next several questions ask about your overall health.

1) In general, would you say your health is:

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

I am going to read a list of activities that you might do during a typical day. As I read each item, please tell me if your health now limits you a lot, limits you a little, or does not limit you at all.

2) .. moderate activities, like moving a table or pushing a vacuum?

- ☐ Yes, limited a lot
- ☐ Yes, limited a little
- ☐ No, not limited at all

3) ...climbing several flights of stairs?

- ☐ Yes, limited a lot
- ☐ Yes, limited a little
- ☐ No, not limited at all

4) During the past four weeks, how much of the time have you accomplished less than you would like as a result of your PHYSICAL health?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

5) During the past four weeks, how much of the time were you limited in the kind of work or regular daily activities that you do as a result of your PHYSICAL health?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

6) During the past four weeks, how much of the time have you accomplished less than you would like as a result of your EMOTIONAL health?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time

- ☐ A little of the time
- ☐ None of the time

7) During the past four weeks, how much of the time did you do work or other daily activities less carefully than usual as a result of any emotional problems, such as feeling depressed or anxious?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

8) During the last 4 weeks, how much has pain interfered with your normal work (including work outside and inside the house)?

- ☐ Not at all
- ☐ A little bit
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

9) How much of the time in the last 4 weeks did you feel calm and peaceful?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

10) How much of the time in the last 4 weeks did you have a lot of energy?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

11) How much of the time in the last 4 weeks did you feel down hearted and depressed?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

12) During the past 4 weeks, how much of the time has your physical or

emotional health interfered with your social activities, like visiting friends or relatives?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

Satisfaction

"I would like to ask you some questions about the services you have received as an outpatient over the last three months?"

1) How would you rate the quality of service you received?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

2) Did you get the service you wanted?

- ☐ No, definitely not
- ☐ No, I don't think so
- ☐ Yes, I think so
- ☐ Yes, definitely

3) To what extent has the outpatient practice met your needs?

- ☐ Almost all of my needs have been met
- ☐ Most of my needs have been met
- ☐ Only a few of my needs have been met
- ☐ None of my needs have been met

4) If a friend were in need of similar help, would you recommend the practice to him/her?

- ☐ No, definitely not
- ☐ No, I don't think so
- ☐ Yes, I think so
- ☐ Yes, definitely

Data Collection

I would like to thank you for your attention and participation in this interview. I would like to remind you that I will be sending a summary of this interview to your primary care clinician. I would also like to ask your permission to use the

information that we have collected today for ongoing research to better understand the behavioral health needs of our patients. If you agree, we will also review your clinical chart to get information about the services and medications you have received here. These data may be used to publish articles but you should know that all of this information is kept strictly confidential. You will never be identified as a participant in this research in any publication. You should also know that you can refuse to allow us to use your data in this way, in which case only a summary of the interview will be placed on your clinical chart. Do you have any questions about this?

1) May we include the data we collect from you for our research?

- ☐ YES
- ☐ NO